(45) days after notification of the claim, interest shall accrue beginning on the forty-sixth day after the date of receipt of the claim at a rate equal to one percent (1%) per month of the unpaid balance of the claim until the claim is paid. The interest shall be payable by the health carrier to the health care provider, individual insured, or other entity submitting the claim. If the health carrier denies or suspends a claim that is subsequently determined to be the liability of the health carrier, the health carrier will be responsible for the interest from the forty-sixth day of the original date of notification of the claim until the claim is actually paid.

2. Any improperly denied claims that are subsequently determined to be payable shall have interest calculated from the forty-sixth day after the date of receipt of the claim.

3. The health carrier may wait until the claimant's aggregate interest payments reach five dollars ($5) before making interest payment to the claimant.

(B) Duties of the Health Carrier.

1. When a health carrier pays or denies a claim, it shall explain in sufficient detail how each item or service was reimbursed. Specifically, if the health carrier has a contract rate with the health care provider, the health carrier shall indicate which items or services are included in the reimbursement and which items are not included in the reimbursement.

2. Pursuant to the requirements of 20 CSR 100-8.040, health carriers shall maintain and legibly date stamp all documentary material related to the pertinent events of a claim. Pertinent events shall include, but not be limited to, the date of the notification of claim, date of payment, date of denial, date of suspension, reason for denial or suspension, amount paid, amount denied, amount suspended, date additional information is requested, the nature of the specific additional information requested, and the date such additional information was received.

3. After notification of a claim, if any information on the claim that affects the amount of benefits payable is changed or omitted in the processing of the claim, including any electronic edits, the health carrier or its third-party contractor shall notify the claimant of the modification in writing with specificity.

4. Any contractual agreement between the health carrier and any of its third-party contractors that receives or processes claims, obtains the service of a health care provider to provide health care services, or issues verifications or pre-authorizations may not be construed to limit the health carrier's authority or responsibility to comply with all applicable statutory and regulatory requirements of this rule or of sections 376.383 and 376.384, RSMo.

5. Contracts between health care providers, health carriers, and their respective third-party contractors shall not extend the statutory or regulatory time frames set forth in this rule or in sections 376.383 and 376.384, RSMo.

(C) Complaints Against Health Carriers. Every complaint made by a health care provider to the director shall include: the health care provider's name, address, and daytime phone number; the health carrier's name; the date of service and date the claim was filed with the health carrier; all relevant correspondence between the health care provider and the health carrier, including requests from the health carrier for additional information; a copy of the confirmation of receipt or acknowledgment of the date of receipt of the claim from the health carrier or its third-party contractor, if available; and additional information which the health care provider believes would be of assistance in the department's review.

AUTHORITY: sections 375.045 and 376.1007, RSMo 2000 and sections 376.383 and 376.384, RSMo Supp. 2007. Original rule filed Sept. 5, 2008.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing will be held on this proposed rule at 10:00 a.m. on November 18, 2008. The public hearing will be held at the Harry S Truman State Office Building, Room 530, 301 West High Street, Jefferson City, Missouri. Opportunities to be heard at the hearing shall be afforded to any interested person. Interested persons, whether or not heard, may submit a written statement in support of or in opposition to the proposed rule, until 5:00 p.m. on November 25, 2008. Written statements shall be sent to Tamara Kopp, Department of Insurance, Financial Institutions and Professional Registration, PO Box 690, Jefferson City, MO 65102.

SPECIAL NEEDS: If you have any special needs addressed by the Americans With Disabilities Act, please notify us at (573) 751-2619 at least five (5) working days prior to the hearing.

Title 20—DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
Division 100—Insurer Conduct
Chapter 1—Improper or Unfair Claims Settlement Practices

PROPOSED RULE

20 CSR 100-1.070 Identification Cards Issued by Health Carriers

PURPOSE: This rule sets forth the requirements for an identification card issued to insureds or enrollees by health carriers offering health benefit plans.

(1) Applicability. This rule applies to all health carriers offering or providing a plan of health insurance, health benefits, or health services to individuals and groups, or administering health benefit plans on behalf of self-insured employer groups.

(2) Definitions. As used in this section—

(A) "Health benefit plan" shall mean health benefit plan as defined in section 376.1350(18), RSMo; and

(B) "Health carrier" shall mean health carrier as defined in section 376.1350(22), RSMo.

(3) Identification Cards.

(A) An identification card or similar document issued to insureds or enrollees shall include the following information:

1. The name of the enrollee or insured;

2. The first date on which the enrollee or insured became eligible for benefits under the plan or a toll-free number that a health care provider may use to obtain such information; and

3. Indicate that the health benefit plan offered by the health carrier is regulated by the Department of Insurance, Financial Institutions and Professional Regulation by placing "DOI" on the front.

(B) Nothing shall prohibit the issuer of a health benefit plan from using an identification card containing a magnetic strip or other technological component enabling the electronic transmission of information, provided that the information required in this section is printed on the card.

(C) The requirements of this section shall apply to all health benefit plans issued or renewed twelve (12) months after this rule becomes effective.

AUTHORITY: sections 375.045 and 376.1007, RSMo 2000 and sections 376.383 and 376.384, RSMo Supp. 2007. Original rule filed Sept. 5, 2008.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed rule will cost private entities approximately $76,800,000 in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: A public hearing will be held on this proposed rule at 10:00 a.m. on November 18, 2008. The public hearing will be held at the Harry S Truman State Office Building, Room 530, 301 West High Street, Jefferson City, Missouri. Opportunities to be heard at the hearing shall be afforded to any interested person. Interested persons, whether or not heard, may submit a written statement in support of or in opposition to the proposed rule, until 5:00 p.m. on November 25, 2008. Written statements shall be sent to Tamara Kopp, Department of Insurance, Financial Institutions and Professional Registration, PO Box 690, Jefferson City, MO 65102.

SPECIAL NEEDS: If you have any special needs addressed by the Americans With Disabilities Act, please notify us at (573) 751-2619 at least five (5) working days prior to the hearing.

FISCAL NOTE
PRIVATE COST

I. RULE NUMBER

Rule Number and Name:	**20 CSR 100-1.070 Identification Cards Issued by Health Carriers.**
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the proposed rule:	Classification by types of the business entities which would likely be affected:	Estimate in the aggregate as to the cost of compliance with the rule by the affected entities:
384	Licensed group health insurance companies	$76,800,000.00

III. WORKSHEET

$200,000 per company
x 384 companies with A&H Authority

$76,800,000 in the aggregate.

IV. ASSUMPTIONS

The cost to private entities of complying with this regulation will vary according to the business practice, volume of business and methods of compliance by each licensee. The cost of compliance includes printing the pre-existing forms with the added information required by the Proposed Rule. DIFP staff presented the proposed rule to and sought input from the Insurance Advisory Panel on February 28, 2008. DIFP staff also presented the proposed rule to and sought input from Coventry/GHP, United Healthcare, Time Insurance Company, and the Missouri Hospital Association. The estimated cost per company was derived from information received from a large, national carrier. Smaller carriers will likely have lower costs. The cost to make the change in the documentation to indicate under what type of plan the individual is insured is a one-time cost. Once the change has been made in the health carriers' systems to make such a disclosure in the documentation, there will no longer be an added cost, in that health carriers already send out insurance cards.